FEDERAL INTERAGENCY
ANNUAL MEDICAL HISTORY and CLEARANCE FORM for
Wildland Firefighters (Arduous Duty)

****CAUTION****
WHEN COMPLETED, THIS DOCUMENT CONTAINS CONFIDENTIAL MEDICAL INFORMATION AND IS SUBJECT TO THE PROVISIONS OF THE PRIVACY ACT (5 USC 552a)

This medical history form is to be completed every year until age 45. From that age on, physical examinations are to be completed every three years. This form also is to be completed in those years after age 45 in which an exam is not done. An exam or this form must be completed and reviewed *prior* to scheduling an arduous duty performance test (the "Pack Test").

***Personnel Office or Program Manager*: Please enter your name and address below and deliver the form to the person who is to complete this medical history form. Upon receipt of the completed form back from the firefighter, review it to identify any "Yes" answers or other indications of possible medical conditions that require further review by the Agency Health Care Consultant. The Summary Statement (see page 7) either is to be completed indicating that no problems have been identified, or the form is to be referred to the Agency Health Care Consultant and, possibly, to the Medical Review Officer for further action.**

***Firefighter (person to complete this History form)*: Please see the Privacy Act Notice below. Please complete ALL of pages 2 through 5 of this form, sign and date every page, and return the form to the Personnel Office or Program Manager at the address shown. All positive entries in the medical history sections of the form must be explained, and may require further information from your personal physician(s). Incomplete forms, or those missing information, may result in a delay in clearing you for firefighter duties and prevent you from taking the Pack Test. Submitting information that is misleading or untruthful may result in termination, or a failure to be cleared as a firefighter.**

Personnel Office or Program Manager

_____

_____

_____

PRIVACY ACT INFORMATION

The information obtained in the completion of this form is used to help determine whether an individual being considered for wildland fire fighting duties can carry out those duties in a manner that will not unduly risk aggravation, acceleration, exaggeration, or permanently worsening a pre-existing medical condition. Its collection and use are consistent with the provisions of the 5 USC 552a (Privacy Act of 1974), 5 USC 3301, and Executive Orders 12107 and 12564 (Drug Free Federal Workplace).

The information will be placed in your official Employee Medical File, and is to be used only for official purposes as explained and published annually in the Federal Register under OPM/GOVT-10, the OPM system of records notice. Your submission of this information is **voluntary**. If you do not wish to provide the information, you are not required to do so. However, your assignment to wildland fire fighting duties depends on the availability of complete and current occupational health records.

Federal Interagency Annual Medical History and Clearance Form for Wildland Firefighters (Arduous Duty)

Firefighter's Name:	**SS#**
Name of Employing Agency:	**Date of Birth:**
Position/Job Title:	**Gender: Male ☐ Female ☐**
Home Address:	**Date of Last Physical Exam:**
Home Phone:	**Work Phone:**
Signature:	**Current Date:**

This history form and review do not substitute for routine health care or a periodic health examination conducted by your own physician. It is being conducted for occupational purposes only.

MEDICAL HISTORY

Smoking History

This information is needed since smoking increases your risk for lung cancer and several other types of cancer, chronic bronchitis, emphysema, asbestos related lung diseases, coronary heart disease, high blood pressure, and stroke. Please check your smoking status and complete the associated section:

☐ Current Smoker

Number of cigarettes per day _____
Number of cigars per day _____
Number of pipe bowls per day _____
Total years you have smoked _____

☐ Former Smoker

Number of cigarettes per day _____
Number of cigars per day _____
Number of pipe bowls per day _____
Total years you smoked _____

☐ Never Smoked

Alcohol/Drug Use

What is your average alcohol consumption (number of drinks) in a week?

_____Drinks (1 drink = 12 0z. beer, 1 glass wine, or 1.5 oz liquor)

If you drink, what is your usual pattern of drinking?

☐ Weekdays ☐ Weekends ☐ Both

Do you use recreational drugs? ☐ No ☐ Yes
(Describe fully)

Describe Your Physical Activity or Exercise Program

Type of Activity or Exercise _____

_____

Intensity: Low _____ Moderate _____ High _____
(*Examples: Walking Jogging, cycling Sustained heavy breathing and perspiration*)

Duration, in Minutes per Session _____

Frequency, in Days per Week _____

Medications (List all medications you are currently taking, including those prescribed and over-the-counter.)

_____ _____
_____ _____
_____ _____
_____ _____

Date of last Tetanus (Td) shot:

MEDICAL HISTORY (continued)			Every item checked "Yes" must be explained in the spaces below. Copies of pertinent medical records also may be necessary.
GENERAL			
Have you ever been treated with an organ transplant, prosthetic device (e.g., artificial hip), or an implanted pump (e.g., for insulin) or electrical device (e.g., cardiac defibrillator)?	☐ Yes	☐ No	
Since you reached age 18, have you had, or have you been advised to have, any surgery?	☐	☐	
Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past year for other than minor illnesses?	☐	☐	
Have you ever been treated for a mental or emotional condition?	☐	☐	
Have you received, is there pending, or have you applied for a pension or compensation for a disability?	☐	☐	
Do you have any allergies? If "Yes," to what are you allergic? (describe in box on right)	☐	☐	
Are you taking any prescription or over-the-counter medications?	☐	☐	
Is there any reason you are aware of why you should ***not*** take the Pack Test?	☐	☐	
VISION	**Yes**	**No**	
Do you have any eye disease?	☐	☐	
Glaucoma?	☐	☐	
Do you wear hard contact lenses?	☐	☐	
HEARING	**Yes**	**No**	
Do you have any long-term ear disease?	☐	☐	
Difficulty hearing?	☐	☐	
Dizziness or balance problems?	☐	☐	
DERMATOLOGY	**Yes**	**No**	
Do you have any long-term skin disease (other than acne)?	☐	☐	
Dermatitis?	☐	☐	
VASCULAR	**Yes**	**No**	
Do you have or have you had any blood vessel disease?	☐	☐	
Enlarged superficial veins, phlebitis, or blood clots?	☐	☐	
Anemia?	☐	☐	
Hardening of the arteries?	☐	☐	
High blood pressure?	☐	☐	
Stroke or Transient Ischemic Attack (TIA)?	☐	☐	
Aneurysms (Dilated arteries)?	☐	☐	
Poor circulation to hands and feet?	☐	☐	
White fingers when cold or with vibration?	☐	☐	

Firefighter's Signature: Date:

HEART	**Yes**	**No**	
Do you have or have you had any heart disease or murmurs?	☐	☐	
Heart or chest pain (angina), discomfort, or pressure?	☐	☐	
Heart rhythm disturbance or palpitations (irregular beat)?	☐	☐	
Heart attack?	☐	☐	
Family members who developed heart disease at ages under 55?	☐	☐	
Organic heart disease (including prosthetic heart valves, mitral stenosis, heart block, heart murmur, mitral valve prolapse, pacemakers, Wolf Parkinson White (WPW) Syndrome, etc.)?	☐	☐	
Heart surgery?	☐	☐	
Sudden, unexplained loss of consciousness?	☐	☐	

RESPIRATORY	**Yes**	**No**	
Do you have or have you had any (lung or airway) disease?	☐	☐	
Breathing difficulty?	☐	☐	
Asthma (including exercise induced asthma)?	☐	☐	
Do you use inhalers?	☐	☐	
Bronchitis or emphysema (chronic, recurrent, or severe)?	☐	☐	
Shortness of breath with exertion?	☐	☐	
Excessive, unexplained fatigue?	☐	☐	
Tuberculosis?	☐	☐	
Have you ever had a positive TB skin test?	☐	☐	

ENDOCRINE	**Yes**	**No**	
Do you have any endocrine disease?	☐	☐	
Diabetes?	☐	☐	
If "Yes," do you use insulin?	☐	☐	
If you use insulin, how many units per day?			
Thyroid Disease?	☐	☐	
Unexplained weight loss or gain?	☐	☐	

MUSCULOSKELETAL	**Yes**	**No**	
Do you have any musculoskeletal disease?	☐	☐	
Joint pain, arthritis, tendonitis?	☐	☐	
Amputations?	☐	☐	
Loss of use of arm, leg, fingers, or toes?	☐	☐	
Loss of sensation?	☐	☐	
Loss of strength?	☐	☐	
Loss of coordination?	☐	☐	
Chronic back pain? (back pain associated with neurological deficit or leg pain)	☐	☐	

NEUROLOGICAL	**Yes**	**No**	
Do you have or have you had any neurological disease?	☐	☐	
Tremors, shakiness?	☐	☐	
Seizures?	☐	☐	
Spinal Cord Injury?	☐	☐	
Long-term numbness or tingling?	☐	☐	

Firefighter's Signature: Date:

NEUROLOGICAL (continued) Head trauma with persistent problem? Recurring headaches (migraine)? Loss of memory? Insomnia (difficulty sleeping)?	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	
GASTROINTESTINAL Do you have or have you had any gastrointestinal disease? Hernias? Persistent Stomach/Abdominal Pain? Hepatitis, or other liver disease? Active ulcer disease? Irritable bowel syndrome? Passing blood in the stool? Vomiting blood?	**Yes** ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	**No** ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
GENITOURINARY Do you have any genitourinary disease? Blood in urine? Kidney Stones? Difficult or painful urination?	**Yes** ☐ ☐ ☐ ☐	**No** ☐ ☐ ☐ ☐	

Firefighter's Signature: Date:

MEDICAL SCREENING

The medical screening must be performed and recorded by a health care professional. Any licensed or certified health care professional may perform this screening as long as the scope of practice delineated by their license or certification includes the screening functions required here.

Important Note: Your "Yes/No" responses, below, must reflect whether or not the screening findings are ***outside*** the listed standard. A "No" response indicates that the Firefighter's result is considered to **meet** the standard.

Screening Item	Result	Standard (or the Annual form proxy for the standard)	Is The Measurement *Outside* of the Standard?	Comments
1. Height (INCHES)				
2. Weight (POUNDS)				
3. Blood Pressure	/	**Less than or equal to 140/90**	**Yes ☐ No ☐**	
4. Pulse (beats/minute)				
5. Hearing (w/o h. aides) **Wh=Whispered word at 1 foot from ear** **Sp=Spoken word at 1 foot from ear** **(opposite ear covered)***	**Heard?** **R – Wh ☐** **L – Wh ☐** **R – Sp ☐** **L – Sp ☐**	**Thresholds no greater than 40 dB in speech range.** **Wh= about 30 dB** **Sp= about 60 dB** **(Need to hear whisper)**	**Yes ☐ No ☐**	
6. Vision **Uncorrected far:** **Corrected far:** **Color (R/G/Y)**	**R -20/_____** **L -20/_____** **R -20/_____** **L -20/_____** **Can see:** **R G Y** **☐☐☐**	**-Uncorrected far vision of 20/100 or better** **-Corrected far vision of 20/40 or better** **-Can see red/green/yellow.**	**Yes ☐ No ☐**	
Are you aware of any reason this Firefighter should *NOT* take the **Pack Test?			**Yes ☐ No ☐**	

*Based on Ears, Nose, and Throat, by William W. Montgomery in Methods of Clinical Examination: A Physiologic Approach, Third Ed., Judge, Richard D., ed., Little, Brown, and Co., Boston, 1974, pp. 102-103.
**The "Pack Test" requires the Firefighter to carry a 45 pound pack a distance of 3 miles in a period of 45 minutes over level ground. Further information may be obtained from "Fitness and Work Capacity" Second Edition, National Wildfire Coordinating Group, April 1997, Brian J. Sharkey, Ph.D., Project Leader.

Other Comments:

Medical Screening Performed By:

_____
Print Name

_____ _____
Signature Date

_____ _____
License or Certification State of License/Certification

Firefighter's Signature: Date:

Annual Medical History Review Summary Statement

Based upon a review of this form:

☐ **A. There are no significant findings** (All "Yes/No" questions were recorded by the firefighter and screener as "No"). The firefighter is ready for further personnel processing and performance of the Pack Test.

☐ **B. The only significant finding is uncorrected far vision** (All "Yes/No" questions, except that for uncorrected far vision, were recorded as "No"). An acceptable accommodation may be to require the possession during duty hours of a second set of corrective lenses. With this accommodation, the firefighter is ready for further personnel processing and performance of the Pack Test.

☐ **C. Further review by an Agency Health Care Consultant (e.g., RN) or the Medical Review Officer is necessary** (One or more "Yes/No" questions were recorded by the firefighter as "Yes").

Personnel Office or Program Manager: _____ Date: _____

Agency Health Care Consultant's Summary Statement

Necessary only when Personnel Office / Program Manager's finding is C.

Based upon a review of the Annual Year Medical History and any additional information provided by the firefighter's health care providers:

☐ **A. There are no significant findings** - The "Yes" items marked on the form do not represent significant health problems. The firefighter appears to meet the medical standards. The firefighter is ready for further personnel processing and performance of the Pack Test.

☐ **B. There may be significant medical findings** – The "Yes" items marked may represent significant health problems. Further review by the Agency Medical Review Officer is indicated.

Personnel Office Health Care Consultant's Signature: _____Date: _____

Medical Review Officer's Summary Statement

Necessary only when Agency Health Care Consultant's finding is B.

Based upon a review of the Annual Year Medical History and any additional information provided by the firefighter's health care providers:

☐ **No Significant Findings** - The Firefighter appears to meet the medical standards. The firefighter is ready for further personnel processing and performance of the Pack Test.

☐ **A Final Determination Cannot be Made Based on Available Medical Information** - The following results remain inconclusive and require that further information be provided to the Agency Medical Review Officer from the examinee's personal health care providers (see 5 CFR 339.104, attached). Final recommendations cannot be made until this has been completed.

☐ **Significant Medical Findings** - The individual does not appear to meet one or more of the medical standards.

Medical Review Officer's Signature: _____Date:

Attachment to the Federal Interagency Annual Year Medical History and Clearance Form

5 CFR 339.104

Sec. 339.104 Definitions.

For purposes of this part--

. . . .

Medical documentation or documentation of a medical condition means a statement from a licensed physician or other appropriate practitioner which provides information the agency considers necessary to enable it to make a employment decision. To be acceptable, the diagnosis or clinical impression must be justified according to established diagnostic criteria and the conclusions and recommendations must not be inconsistent with generally accepted professional standards. The determination that the diagnosis meets these criteria is made by or in coordination with a physician or, if appropriate, a practitioner of the same discipline as the one who issued the statement. An acceptable diagnosis must include the following information, or parts identified by the agency as necessary and relevant:

(a) The history of the medical conditions, including references to findings from previous examinations, treatment, and responses to treatment;
(b) Clinical findings from the most recent medical evaluation, including any of the following which have been obtained: Findings of physical examination; results of laboratory tests; X-rays; EKG's and other special evaluations or diagnostic procedures; and, in the case of psychiatric evaluation or psychological assessment, the findings of a mental status examination and the results of psychological tests, if appropriate;
(c) Diagnosis, including the current clinical status;
(d) Prognosis, including plans for future treatment and an estimate of the expected date of full recovery;
(e) An explanation of the impact of the medical condition on overall health and activities, including the basis for any conclusion that restrictions or accommodations are or are not warranted, and where they are warranted, an explanation of their therapeutic or risk avoiding value;
(f) An explanation of the medical basis for any conclusion which indicates the likelihood that the individual is or is not expected to suffer sudden or subtle incapacitation by carrying out, with or without accommodation, the tasks or duties of a specific position;
(g) Narrative explanation of the medical basis for any conclusion that the medical condition has or has not become static or well stabilized and the likelihood that the individual may experience sudden or subtle incapacitation as a result of the medical condition. In this context, "static or well-stabilized medical condition" means a medical condition which is not likely to change as a consequence of the natural progression of the condition, specifically as a result of the normal aging process, or in response to the work environment or the work itself. "Subtle incapacitation" means gradual, initially imperceptible impairment of physical or mental function whether reversible or not which is likely to result in performance or conduct deficiencies. "Sudden incapacitation" means abrupt onset of loss of control of physical or mental function.

. . . .

Physician means a licensed Doctor of Medicine or Doctor of Osteopathy, or a physician who is serving on active duty in the uniformed services and is designated by the uniformed service to conduct examinations under this part.

Practitioner means a person providing health services who is not a medical doctor, but who is certified by a national organization and licensed by a State to provide the service in question.